HEALTHY INDIANA PLAN SM

Employer Benefit Link

HIP Link Program FAQs

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Additional information may be found at HIP.IN.gov.

Questions or comments for employers may be sent to HIPLINK.ECT@fssa.in.gov or by contacting 1-800-457-4584.

Employees may send inquiries to HIP2.0@fsss.in.gov or contact 1-877-GET-HIP-9.

General HIP Link FAQs

1) **Q: What is HIP Link?**

A: HIP Link is a new program offered by the State of Indiana as part of the Healthy Indiana Plan to help low income Hoosiers afford their employer-sponsored health insurance. The program is an option for many Hoosiers who are eligible for the Healthy Indiana Plan and helps pay a portion of the employee's premium cost for employer group health insurance.

2) **Q: Who is eligible?**

A: A HIP Link eligible employee must be at least 19 years old with an income at or below approximately 138 percent of the federal poverty level ($16,436 per year for an individual and $33,865 for a family of four) and meet HIP eligibility requirements. Employers interested in offering HIP Link as an option to their employees must register to become a HIP Link employer. Employees who are eligible can elect either HIP Link or HIP coverage and can compare options during enrollment.

3) **Q: How does HIP Link work?**

A: HIP Link is a premium assistance program for employees that are eligible and have access to group health coverage from their employer. The employer must be a HIP Link employer for employees to receive premium assistance. The employer will deduct from the employee's pay the cost or premium charged to the employee for the group health insurance, per their normal procedures. Each month, the state will reimburse the employee directly for the amount of the deduction, (minus their monthly HIP Link POWER Account contribution described below).

4) **Q: What is the HIP Link POWER Account?**

A: Each individual participating in the program will be given a HIP Link Personal Wellness and Responsibility (POWER) Account fully funded with $4,000. This POWER Account is used to pay for premium amounts and other medical expenses charged to the employee up to $4,000 per year.

5) **Q: Will the individual have to contribute anything?**

A: A key feature of the Healthy Indiana Plan is that it promotes personal ownership by requiring participants to contribute a portion of their income (approximately 2 percent of household income) to their health coverage. This is true in the HIP Link program, too. The state will subtract the 2 percent contribution amount from the employee's monthly reimbursement. For an individual with an average income of $16,000 per year, their contribution to participate in the program may be $26.67 per month or $320 annually depending on the total cost of the employer health insurance. For a family of four with an annual income of $30,000, the contribution may be $50 per month or $600 annually depending on the cost of the employee health insurance. In addition to their contributions, HIP Link enrollees receive a separate $4,000 account to cover the costs of premium

reimbursement and out of pocket costs for medical expenses. Once the funds are depleted in the account, the employee will cover costs for the employer insurance up to a total of 5 percent of their household income on a quarterly basis.

6) **Q: What if other family members are covered under my plan?**

A: The funds available to eligible family members that meet the requirements to participate in HIP Link will be pooled together to cover total plan costs with each member receiving $4,000.

7) **Q: What happens when the account is depleted?**

A: If the funds available in the Link account are depleted, the employee will cover costs at the Medicaid allowable cost sharing limits based on their federal poverty level (FPL) as provided in the table below. The member will not be responsible for paying more than a total of 5 percent of quarterly household income for the health insurance offered by the employer. The member's portion will be deducted from their next monthly HIP Link premium reimbursement based on the Medicaid allowable cost sharing amount for medical services received.

Medicaid Allowable Cost Sharing

Service	**Copay Amounts**	
	Individuals with family income ≤ 100% of the FPL	Individuals with family income ≤ 138% of the FPL
Outpatient Services	$4	*10% of the cost
Inpatient Services	$75	*10% of the cost
Preferred Drugs	$4	
Non-preferred Drugs	$8	

*Individuals with income between 100 percent and 138 percent of FPL will pay the higher copay amount of $4 or 10 percent of the cost for outpatient services; or the higher copay amount of $75 or 10 percent of the cost for inpatient services. More information on the federal poverty levels for an individual's family income and size is available at http://www.in.gov/fssa/hip/2458.htm.

8) **Q: What happens when I spend 5 percent of my income on a quarterly basis?**

A: The state will review whether the Link coverage remains cost-effective based on of the costs to remain enrolled in Link as compared to enrolling in the Healthy Indiana Plan (HIP) through the state. If costs are less than they would be in HIP, then the employee will remain in their employer plan through HIP Link and would be responsible or copayments up to the 5 percent of quarterly income limit. If the coverage is not cost-effective, then the employee will no longer be eligible for HIP Link and would be enrolled in the Healthy Indiana Plan Plus program offered by the State of Indiana. Disenrollment from HIP Link does not require the employee to disenroll from their employer-sponsored insurance, however, HIP Link will no longer be available to help pay for premiums and out of pocket costs.

9) **Q: How can I access my Link POWER account?**

A: Each employee and eligible spouse or dependent will receive a HIP Link card. The card will provide the information needed for health providers or pharmacies to submit medical bills to the state. When visiting a doctor, a HIP Link member will need to give the doctor's office both their primary insurance card and their HIP Link card. The doctor will send the bill for the medical care to the health insurance provided through the employer first. Whatever amount is not paid by the employer health insurance, the doctor will bill to HIP Link. The member may not withdraw funds from the HIP Link POWER account, this account is used solely for paying providers and reimbursing the member for premium costs.

Individual Enrollment FAQs

10) **Q: How do I enroll in HIP Link?**

A: If you are not currently enrolled in the Healthy Indiana Plan (HIP), you will first need to find out if you are eligible. You can find out of you are eligible for HIP Link by applying with the Indiana Application for Health Coverage and selecting the HIP Link option. You can learn how to apply for HIP at HIP.IN.gov. If you are currently enrolled in HIP, you can enroll in HIP Link by calling the Division of Family Resources at 1-800-403-0864 and requesting to enroll in HIP Link. To enroll in HIP Link you will need to provide your employer's HIP Link ID. If your employer does not have a HIP Link ID, they can apply to be a HIP Link employer at https://secure.in.gov/apps/fssa/hiplink/#/home.

11) **Q: Can I enroll in HIP Link if I already have health insurance from my employer?**

A: Yes. If you already have health insurance through your employer and are HIP Link eligible you can still enroll in HIP Link. Enrolling in HIP Link would help you pay for the out-of-pocket costs of employer-sponsored insurance and reimburse you for the some of the employee premium. Your eligibility for HIP will first need to be determined. To find out if you are eligible for HIP Link you can apply with the Indiana Application for Health Coverage and select the HIP Link option. You can learn how to apply for HIP at HIP.IN.gov.

12) **Q: Can I enroll in HIP Link if I am in a waiting period for my employer-sponsored insurance?**

A: Yes. If you are in a waiting period for your employer-sponsored insurance you can enroll in HIP Link. You will be given the option to enroll in HIP while you wait for your employer-sponsored coverage to start. Once your employer confirms that you are enrolled in their plan and your employer coverage has started, your HIP Link supplemental coverage will start. You will receive monthly reimbursement for premiums paid to your employer that are in excess of your 2 percent of income HIP Link contribution, and your HIP Link POWER account which will help cover your premiums and out of pocket expenses.

13) **Q: Can I enroll in HIP Link if I did not enroll in health insurance during the open enrollment period?**

A: Yes. Becoming eligible for HIP Link will qualify you for a special enrollment period. Once you are eligible for HIP Link you will have 60 days from when your employer verifies you are eligible for their coverage to enroll in your employer-sponsored plan so that you can start HIP Link coverage.

14) **Q: What do I have to do to reenroll in HIP Link for the next benefit year?**

A: HIP Link members will need to complete any verifications requested by the State to confirm their continued HIP Link eligibility and will need to complete any enrollment forms required by the employer.

15) **Q: What if the employer plan I am enrolled in is not my employer's HIP Link plan?**

A: Not all employer-sponsored health plans will conform to the requirements necessary to qualify them as HIP Link plans. If your employer offers a plan that is not a HIP Link plan and you are enrolled in that plan, you will have 60 days to transfer to a HIP Link eligible plan. If you do not transfer to a HIP Link eligible plan you will remain in your current plan until the benefit period ends. You may review coverage options during the open enrollment period and make changes at that time. The plan changes made during the open enrollment period will be effective for the next benefit period or calendar year.

16) **Q: How will my employer know I am eligible for HIP Link?**

A: Employers that participate in HIP Link have access to an electronic portal where they can verify that individuals are eligible for their health insurance and provide information on the health insurance benefits. After you are determined eligible for HIP Link, the state will contact the employer to confirm your employment status and other health coverage information. After confirmation is complete, you will be listed as a HIP Link employee and will be notified when program benefits begin.

17) **Q: What is the difference between HIP and HIP Link?**

A: The Healthy Indiana Plan (HIP) now has multiple programs, such as HIP Plus, HIP Basic and HIP Link. The entire program has generally the same eligibility criteria (age 19 to 64, income of 138 percent of the federal poverty level or less, etc.) HIP Link is a unique program within the Healthy Indiana Plan that allows HIP-eligible individuals to use their HIP Link POWER Accounts to purchase health coverage through their employer. To be able to enroll in HIP Link an individual must be HIP eligible and have access to employer-sponsored insurance that is HIP Link eligible. Individuals eligible for HIP Link may choose to enroll either in HIP (Plus or Basic coverage through the State of Indiana) or in their employer plan through HIP Link. If the individuals enroll in HIP Link they receive the health benefits available on their employer-sponsored insurance which will be different than the health benefits available in HIP. Individuals in HIP Link may receive coverage for benefits not covered in HIP, like chiropractic care, or not have access to benefits that are covered in HIP like bariatric surgery or TMJ treatment. The benefits covered in HIP Link vary from employer to employer, depending on the health insurance plan provided.

Individuals enrolled in HIP Link receive a HIP Link POWER Account valued at $4,000 which will be used to cover premiums and other out-of-pocket costs of their employer-sponsored insurance. Once the funds are depleted in the account, the employee will cover costs at the Medicaid allowable cost sharing limits for the employer insurance up to a total of 5 percent of their household income on a quarterly basis.

In HIP, instead of being enrolled in the employer-sponsored insurance, individuals choose a managed care company to oversee their health care. HIP Plus enrollees contribute to a $2,500

POWER account. The HIP POWER account covers the first $2,500 of health care expenses. More information on HIP benefits is available at HIP.IN.gov.

In both HIP and HIP Link individuals contribute 2 percent of their income towards the costs of their health insurance.

18) **Q: Who do I contact if I need help understanding my health coverage options?**

A: The state's enrollment broker, MAXIMUS, can help individuals understand their options and walk through the benefits covered on the employer-sponsored insurance and the Healthy Indiana Plan. MAXIMUS can be contacted at 1-877-GET-HIP-9. Staff available at that number can also help determine if a particular health care provider is contracted (in network) to provide care in HIP. Individuals may need to contact their employer sponsored health insurance for more information on in network providers with the employer plan.

Employer Enrollment FAQs

19) **Q: What are the benefits of becoming a HIP Link employer?**

A: HIP Link employers may be able to enroll more of their employees into their employer-sponsored insurance. This may help some employers meet health plan participation requirements. Small employers using the Health Insurance Marketplace may receive tax benefits. In addition, registering as a HIP Link employer and offering another benefit option for low income employees may help improve employee retention and satisfaction.

20) **Q: How does an employer become a HIP Link employer?**

A: To become a HIP Link employer, you must employ Indiana residents, contribute at least 50 percent to the premium cost for employee only or single coverage type offered and complete an online application. This application is available at https://secure.in.gov/apps/fssa/hiplink/#/home. After review and approval, the employer will receive a HIP Link Employer ID. Eligible employees may then enroll in the program.

21) **Q: What are the technical requirements to complete the online employer application?**

A: The minimum requirements for accessing the employer application include Internet Explorer 10 or newer, or the latest versions of Firefox, Safari or Chrome. If your browser is an older version, you will be prompted to upgrade to the latest version to complete the employer application. In addition, when uploading required documents, file size cannot exceed 20MB and file name cannot exceed 100 characters.

22) **Q: What information is needed to complete the HIP Link employer application?**

A: The employer will need to provide general business information, such as federal employer identification number (FEIN), primary contact and business address. Additionally, health insurance plan information is needed, such as benefit summaries and premium rates for the employers and employees. Employers can find more information in the employer manual available at HIP.IN.gov.

23) **Q**: **Are there any fees associated with becoming a HIP Link employer?**

A: No, there are no costs. Registering as a HIP Link employer does not have any associated fees.

24) **Q: Who do I contact for more information?**

A: Employers may contact 1-800-457-4584 or HIPLINK.ECT@fssa.in.gov for more information.

25) **Q: Will employers change how they deduct employees' premium amounts from payroll?**

A: No. There will be no changes to how employers deduct premium amounts from payroll.

26) **Q: Can employers continue to make contributions to Health Savings Accounts (HSAs) for employees enrolled in HIP Link?**

A: No. HIP Link provides supplemental coverage for out-of-pocket expenses. Employees are only eligible for tax exempt contributions to a HSA when their high-deductible plan is their only source of coverage. To prevent employees from facing tax penalties or other consequences, employers cannot make HSA contributions for HIP Link eligible employees.

27) **Q: Can employers offer Health Reimbursement Accounts (HRAs) for employees enrolled in HIP Link?**

A: Yes. HRAs can be administered the same for all employees as currently operated if offered by the employer. Employers can continue to make contributions to HRAs.

28) **Q: Can multi-employer plans, unions or Professional Employer Organizations (PEOs) apply for HIP Link?**

A: Yes, unions and PEOs can apply for HIP Link through the employer application.

29) **Q: How will employers know if an employee is eligible for HIP Link?**

A: HIP Link eligible employees will be communicated to the employer from the online employer portal. The employer will receive an email when one of their employees is eligible for HIP Link. The employer will need to verify employee data.

30) **Q: Once an employer plan is approved for HIP Link, what are the responsibilities for the employer?**

A: Once enrolled as a HIP Link employer, employers will need to confirm new HIP Link eligible employees' eligibility for the program and communicate any relevant employer changes, such as a change in business address or group health plan. On a monthly basis, the HIP Link employer will be prompted to confirm through the employer portal that employees enrolled in HIP Link are still employed and eligible for health insurance coverage. On an annual basis, employers will confirm if the benefits or premiums for the HIP Link eligible employer plans have changes effective for the new or subsequent benefit period.

31) **Q: How long will the employer have to enroll the employee in coverage and for it to become active?**

A: Becoming eligible for HIP Link is considered a qualifying event for the purposes of making plan changes or newly enrolling in a plan. Therefore, employees can enroll in HIP Link during a special enrollment period. The special enrollment period will allow for the employee to make the new election or coverage within 60 days. The 60 day special enrollment period will begin when the employer verifies the employee is eligible for HIP Link. The coverage is active based on the coverage effective date as provided by the employer.

New employees may be subject to a waiting period. HIP Link coverage would begin for eligible employees after that period. The employer will be asked to provide their waiting period in the employer application, if applicable. The employee may opt to enroll in the Healthy Indiana Plan in the meantime and, if eligible, could transition to HIP Link coverage at the end of the waiting period.

32) **Q: Will the employer be required to make HIP Link coverage effective on the first of the month?**

A: No. The employer-sponsored insurance coverage start date is determined by the employer. HIP Link coverage or program benefits will always begin on the first of the month regardless of when the employer coverage begins. Once an individual is verified as HIP Link eligible, HIP Link will be available to the individual beginning the first day of the month in which they are also enrolled in employer-sponsored insurance. This could be as soon as the month that the employer completes the verification. Employees subject to waiting periods may enroll in HIP while waiting to be eligible to start HIP Link coverage.

33) **Q: How do open enrollment periods impact HIP Link?**

A: HIP Link requires an annual eligibility verification to ensure employees continue to meet eligibility requirements. After the initial enrollment, the HIP Link eligibility verification will align with the employer's open enrollment period and coverage start date. Eligibility for HIP Link is a qualifying event in which employees may enroll in the program during a special enrollment period.

34) **Q: What happens if a HIP Link eligible employee selects a plan that does not qualify for HIP Link?**

A: The employer will be notified which group health plans are HIP Link eligible plans upon approval of their employer application. To get the HIP Link premium support, eligible employees must enroll in a HIP Link eligible plan. If a HIP Link eligible employee elects a plan other than the HIP Link plan, the employee will not receive the premium assistance or funds to cover out-of-pocket expenses. Employers will be able to notify HIP Link eligible employees of what plans are HIP Link eligible. Since becoming eligible for a premium assistance program like HIP Link is a qualifying event, eligible employees not enrolled in an eligible HIP Link plan, may change plans during a special enrollment period to enroll in an eligible HIP Link plan as offered by the employer.

35) **Q: How do I tell my employees about the program?**

A: HIP Link information and material can be found at HIP.IN.gov. Employees may contact 1-877-GET-HIP-9 or HIP2.0@fssa.in.gov.

36) **Q: What is a HIP Link eligible plan?**

A: To be HIP Link eligible, a plan must meet the HIP Link benefit and affordability requirements as provided in the employer manual available at HIP.IN.gov.

37) **Q: What are the HIP Link benefit requirements?**

A: A small employer that offers a plan that is updated to meet the 2014 Affordable Care Act (ACA) requirements will meet the benefit requirements to participate in HIP Link. The different employer plan types are described in the FAQ sections for small, large and self-funded businesses. Other types of plans offered by the employer may be HIP Link eligible, but need to meet the state's essential health benefit requirements *or* meet the federal requirements for minimum value and offer benefits in all of the following essential health benefit categories including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and Pediatric services

Indiana's essential health benefits are displayed at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf. Minimum value requirements are described at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mv-calculator-methodology.pdf.

Additionally, a plan must comply with the parity protections for mental health and substance use disorder services. Information concerning the parity protections for mental health and substance use disorder services are displayed at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html. The health plan should not cover abortion services for which federal funding is prohibited. Federal law prohibits federal funds from being used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered). Federal abortion law displayed at: http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited. State law prohibits health plans from providing coverage for abortion (except in cases of rape or incest, or when the life of the woman would be endangered). State abortion law displayed at: https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/.

38) **Q: How are benefit requirements verified?**

A: Benefits are verified by the employer attesting that the plan meets the medical benefits and services required by the program. Additionally, the employer will upload a plan's summary of

benefits and coverage (SBC) or benefit summary, schedule of benefits, certificate of coverage or summary plan description and prescription drug formulary for a HIP Link employer counseling team member to review as part of the employer application.

39) **Q: Will HIP Link cover dental and vision benefits?**

A: If the employer offers dental and vision benefits to their employees, these benefits will be eligible to be reimbursed by HIP Link.

40) **Q: What are the HIP Link affordability requirements?**

A: The $4,000 account must be able to cover the employee portion of premiums in excess of the employees 2 percent contribution and the expected out of pocket costs for the enrollee. An example of a plan that may meet the program's cost structure based on the average income of an eligible employee is an employee premium that is less than $1,120 annually with a deductible of $2,500 and an out-of-pocket limit of $4,000 annually.

41) **Q: How is plan affordability verified?**

A: The state will make an affordability decision. The employer will need to include their premium rates, benefit summaries and Health Reimbursement Account (HRA) contributions, if offered, as part of the employer application submission for review. With these summaries, the state will verify that the $4,000 HIP Link account and individual and employer contributions will be sufficient to make the health plan affordable under the Medicaid requirements.

42) **Q: Are there health plans that have been determined by the state as eligible HIP Link plans?**

A: Insurance plans can apply to become an eligible HIP Link plan by submitting benefit only information for review. The plans will receive an eligible HIP Link Plan ID. Insurance plans can apply for HIP Link by completing the online form at https://secure.in.gov/apps/fssa/insurers-application-form/. More information is available at HIP.IN.gov.

43) **Q: How can I know that my plan is HIP Link eligible?**

A: Some health plans will apply to the program to become eligible HIP Link plans. These plans have a HIP Link Plan ID and can provide this ID to the employer. Employers with eligible HIP Link plans may not have to complete some of the health insurance information on the application. For more information, the employer may contact HIPLINK.ECT@fssa.in.gov when completing the employer application.

44) **Q: How can an employer know if the plan is already screened as a HIP Link eligible plan?**

A: Employers would need to contact their health insurance agent or the insurance company that offers the plan to apply for the HIP Link eligible group health insurance coverage.

Employee Eligibility and Enrollment FAQs

45) **Q: Who is eligible to participate in HIP Link?**

A: To participate in HIP Link, employees must have access to and be eligible to participant in their HIP Link employer's group health plan. The employee must also be 19 years of age or older with a household income equal to or less than approximately 138 percent of the federal poverty level and meet HIP eligibility requirements. For HIP Link eligible employers, employees with household incomes of up to $16,436.81 annually for an individual, $22,246.25 for a couple or $33,865.13 for a family of four are generally eligible to participate in HIP Link.

Income Guidelines for HIP Eligibility

Household size	Monthly income limit for HIP Link eligibility	Annual income limit for HIP Link eligibility
1	$1,369.73	$16,436.80
2	$1,853.85	$22,246.25
3	$2,337.97	$28,055.69
4	$2,822.09	$33,865.13
5	$3,306.21	$39,674.57
6	$3,790.33	$45,484.01
7	$4,274.45	$51,293.45
8	$4,758.57	$57,102.89
For each additional person, add:	$484.12	$5,809.44

46) **Q: How do employees get HIP Link?**

A: To be eligible for HIP Link and enroll in the program, employees must apply for and be eligible for HIP. Information on how to enroll is available at HIP.IN.gov.

47) **Q: Can the employee's spouse or children participate?**

A: Spouses and dependents that are 19 years of age or older that are covered on the HIP Link eligible insurance may be eligible for HIP Link if they meet the HIP eligibility requirements.

48) **Q: Can early retirees participate in the program?**

A: Early retirees can participate in the program if the retiree meets the HIP Link eligibility requirement and their employer and health plan meets the program benefit and affordability requirements.

49) **Q: What health benefits are offered in HIP Link?**

A: HIP Link benefits may vary by employer. For employer group health coverage in the commercial market, the employer selects the type of benefits or plan to offer employees. For HIP Link, employers that choose to participate must offer benefits that meet the program's benefit requirements.

50) **Q: Where can I fill my prescriptions?**

A: Prescriptions must be filled at a pharmacy that is enrolled as an Indiana Health Coverage Programs provider to be eligible for immediate payment from HIP Link. The employer plan may also have in network requirements. By going online to http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx or calling the State's enrollment broker, MAXIMUS, at 1-877-GET-HIP-9 HIP Link members can receive help finding enrolled providers. HIP Link enrollees that fill a prescription at a non-HIP Link pharmacy, can be reimbursed by HIP Link, but they would have to pay out of pocket and then submit the expense to HIP Link as described below.

51) **Q: What doctors are in-network for HIP Link?**

A: All HIP Link providers must be enrolled with the Indiana Health Coverage Programs (IHCP). The employer plan may also have in network requirements. To find an IHCP provider, HIP Link members can go online to http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.aspx or contact Maximus at 1-877-GET-HIP-9.

52) **Q: What if I receive services from a provider not enrolled with the Indiana Health Coverage Programs, but is in-network on the employer plan?**

A: HIP Link will only pay providers that are enrolled in the Indiana Health Coverage Programs (IHCP) for the member's portion, such as copayments, of the service received. However, HIP Link may reimburse the member for their amount paid for the service received less the Medicaid allowable cost sharing limits from a provider who is not enrolled with the Indiana Health Coverage Programs, but is an in-network provider on the employer plan. You will receive reimbursement for this service on your next monthly HIP Link premium reimbursement. The member will need to submit the following information to HIP2.0@fssa.in.gov or mail to P.O. Box 1995, Indianapolis, IN 46207-1995 for reimbursement: their name and RID, HIP Link employer ID, provider invoice, receipt of payment and explanation of benefits (EOB). The information will be reviewed and may be counted towards the member's 5 percent cost limit. For additional billing questions, contact 1-800-457-4584.

HIP Link will only reimburse the member for services received as described above from providers not enrolled with the IHCP, but is an in-network provider on the employer plan.

53) **Q: How will HIP Link help employees cover out-of-pocket costs associated with their employer-sponsored insurance?**

A: HIP Link will cover medical expenses that are the employee's financial responsibility with the funds provided in the Link account. Medical expenses include payments required for doctor office visits or prescription costs. The member will present his or her HIP Link card to health providers or pharmacies. The member's portion of the payment will be submitted to HIP Link.

54) **Q: How will employees manage the funds in the HIP Link POWER Account?**

A: Each employee will receive a monthly statement in the mail outlining their HIP Link POWER account activity. The account activity includes the funds used to pay providers or pharmacies for the medical services received. The employee is encouraged to review account activities and manage their HIP Link POWER account to become more actively involved in their healthcare spending.

55) **Q: Will employees be allowed to enroll in HIP Link outside of the employer's open enrollment period?**

A: Yes, becoming eligible for a premium assistance program like HIP Link is considered a qualifying event as defined under Internal Revenue Code Section 125. Employees that become eligible for HIP Link will be eligible for a special enrollment into their employer-sponsored health plan.

56) **Q: When will HIP Link employee eligibility be determined and how often?**

A: The HIP Link employee and their eligible spouse or dependents will be subject to an annual redetermination to ensure that they continue to meet HIP eligibility requirements. This redetermination period will align with the end of the employer's benefit period. The employee is required to meet HIP eligibility requirements throughout the year. The member's responsibilities include informing the state of any change in household income. If an individual is already enrolled in HIP and requests to be determined for eligibility for HIP Link, then HIP Link employee eligibility will be determined at member's request.

57) **Q: Can employees enroll in HIP Link during the employer's open enrollment period?**

A: Yes, the eligible HIP Link employees can enroll in HIP Link during an eligible employer's open enrollment period. Employees may also enroll during a special enrollment period if determined eligible outside the employer's open enrollment period. A special enrollment period is allowed since becoming eligible for a premium assistance program like HIP Link is a qualifying event. This may be applicable to new employees, employees already enrolled in group health coverage or employees who are not enrolled.

58) **Q: How long is the special enrollment period?**

A: The special enrollment period is 60 days. The 60 day special enrollment period will begin when the employer verifies the employee is eligible for employer benefits.

59) **Q: What happens to a member's Health Savings Account (HSA) account when an employer stops contributing due to HIP Link enrollment?**

A: The remaining funds in the HSA account are available for the employee to use for out-of-pocket expenses for health services or other related health expenses.

60) **Q: Can I also use my Health Reimbursement Account (HRA), if medical expenses are paid from the HIP Link account?**

A: Yes, HRA contributions or arrangements are managed by the employer. HRA contributions may continue while a member is enrolled in HIP Link.

61) **Q: What if I receive services from a provider that is out-of-network on the employer plan?**

A: In general, HIP Link will not reimburse members or providers for services received from providers that are not in the employer plan's network. Members should always verify with their employer insurance what providers are in network and what services are covered. In limited instances for

services that are available through HIP Link regardless of the coverage on the employer plan (family planning services, early periodic screening diagnoses and testing services, services provided and federally-qualified and rural health centers, etc.) HIP Link will cover services received at providers that are out of network with the employer plan. These providers must be Indiana Health Coverage Programs (IHCP) enrolled for these HIP Link services to be covered. To find an IHCP enrolled provider, contact 1-877-GET-HIP-9. To find providers in network with your employer plan, please contact the employer plan directly.

Employer Disenrollment FAQs

62) **Q: Are employers required to report disenrollment reasons?**

A: The employer is only required to report disenrollment reasons that are due to changes in the group health insurance, such as the employer is no longer offering health insurance. Also, employers are required to report changes that may impact the employer's eligibility as a HIP Link employer. On a monthly basis, employers will be asked to confirm employee enrollment status through the portal, but no other reporting on employees is required. .

Employee Disenrollment FAQs

63) **Q: What happens if the employee exhausts all the funds in the POWER Account available to cover plan costs?**

A: If the entire amount of funds is depleted in the HIP Link account, the employee will then become responsible for covering medical costs at the Medicaid allowable cost sharing up to 5 percent of their household income on a quarterly basis. This amount will be deducted from the employee's next monthly HIP Link premium reimbursement based on the cost sharing amounts for medical services received. When the account is exhausted the state will examine if the ESI is still cost-effective, the employee will remain in their employer plan through HIP Link but would not be responsible for costs beyond the 5 percent threshold if the plan remains cost-effective. If the coverage is not cost-effective then the employee will no longer be eligible for HIP Link and would be encouraged to enroll in the Healthy Indiana Plan Plus program offered by the State of Indiana.

64) **Q: Are employees allowed to leave the program?**

A: Yes, there are certain events that qualify the individual to disenroll from HIP Link and enroll in HIP or another Medicaid benefit. These events include:

- Individual becomes pregnant.
- Individual develops a serious medical, mental or behavioral health condition.
- Individual coverage is not cost effective.
- Individual coverage ends due to the HIP Link plan no longer meeting the program requirements.
- Individual becomes ineligible for group health coverage from their employer.

- Eligible spouse or dependent becomes ineligible for group health coverage from the employer.

The employee is allowed to disenroll or terminate from group health coverage since the individual became eligible for a new benefits package which is HIP.

Employees may also elect to disenroll from HIP Link during the employer's open enrollment period or their annual redetermination.

65) **Q: What if my income changes?**

A: Individuals who become ineligible for HIP will be disenrolled from HIP Link and will no longer receive premium reimbursement or help paying for out of pocket costs. The individual may continue to be enrolled in the employer plan.

66) **Q: Is the employee *required* to disenroll from the program if one of the disenrollment events occurs?**

A: The employee will have the option to either stay enrolled in HIP Link or transfer to HIP upon becoming pregnant or developing a serious medical condition. If the employee transfers to HIP, the individual must remain in HIP for the remainder of the group plans' benefit period. Additionally, pregnant women cannot enroll in HIP Link on the initial application.

67) **Q: Is an employee who is on Family and Medical Leave Act (FMLA) disenrolled from HIP Link?**

A: Employees under FMLA who may no longer be receiving monthly payroll will be reviewed on a case by case basis for disenrolling from HIP Link.

68) **Q: Can the employee come back to HIP Link after he or she disenrolls?**

A: Yes, if the employee and employer meet HIP Link eligibility requirements. HIP Link allows for the employee to enroll in HIP Link during open enrollment periods. An employee may have one opportunity to enroll in the employer's special enrollment period every two years.

69) **Q: Can the employee come back to HIP Link after pregnancy if she chooses to transfer to HIP?**

A: Pregnancy coverage in HIP continues through the postpartum period up to 60 days. The employee may come back to HIP Link after the group plan's benefit period ends.

70) **Q: Does the employee or member need to inform the employer if the individual is no longer eligible for HIP Link?**

A: Yes, the employee or member needs to notify the employer when the individual is no longer eligible for HIP Link or disenrolling from the program. The employee or member has 30 days from when determined eligible for a different benefit, such as Medicaid to make a change or disenroll from HIP Link. The employer will terminate the employer-sponsored insurance coverage for the applicable member and end or modify the premium amount deducted from the employee's payroll.

FAQs Specific to Businesses with Small Group Plans

71) **Q: What are the qualifications for a small business owner to enroll in HIP Link?**

A: Small businesses with a Federal Employer Identification Number (FEIN) that employ 50 or fewer fulltime employees and have at least one employee that is an Indiana resident may be able to qualify for HIP Link. For employees to be able to participate in HIP Link, the employer must offer a HIP Link eligible health plan and pay at least 50 percent of the premium cost of the employer-sponsored health insurance.

72) **Q: What types of health plans for small business owners qualify for HIP Link?**

A: Health plans offered by small business owners are reviewed and regulated by the Indiana Department of Insurance (IDOI).

The following are the names and descriptions of the different types of plans that are offered to small business owners:

- Small Group Health Plan updated to meet the 2014 ACA requirements – These plans are available to businesses with 50 or fewer fulltime employees and are also known as nongrandfathered plans or qualified health plans (QHP). These plans may have been purchased on the Small Business Health Options Program (SHOP) online marketplace or purchased as a small group health plan or a QHP independent of the SHOP. These plans meet the benefit requirements to be HIP Link eligible, but would need to be verified as affordable.
- Small Group Health Plan NOT updated to meet the 2014 ACA requirements – These plans are available to businesses with 50 or fewer fulltime employees and are also known as grandfathered plans or transitional plans. Employers with grandfathered plans have had their plans since March 23, 2010, or prior. Employers with transitional plans have not changed their plan since 2013. In general, these plans have not had changes to benefits or the employee's cost since plan inception. These plans are not guaranteed to meet the benefit requirements for HIP Link and may offer benefits on a rider. Due to federal requirements, any small group policy that offers benefits on a rider cannot be HIP Link eligible. These plans will need to be verified by the state as meeting the benefit and affordability requirements.
- Non-Indiana Small Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Employers will select the type of plan offered in the employer application and attest to meeting the program's benefit requirements.

FAQs Specific to Businesses with Large Group Plans

73) **Q: What are the qualifications for a large business owner to enroll in HIP Link?**

A: Large businesses with a Federal Employer Identification Number (FEIN) that employ 51 or more employees and have at least one employee that is an Indiana resident may be able to qualify for HIP Link. For employees to be able to participate in HIP Link, the employer must offer a HIP Link eligible health plan and pay at least 50 percent of the premium cost of the employer-sponsored health insurance.

74) **Q: What types of health plans for large business owners qualify for HIP Link?**

A: Health plans offered by large business owners are reviewed and regulated by the IDOI. The following are the names and descriptions of the different types of plans that are offered to large business owners:

- Large Group Plan updated to meet the 2014 ACA requirements – These plans are available to employers with 51 or more employees. These plans meet most of the requirements to be HIP Link eligible, but would need to be verified by the state as meeting the benefits and affordability requirements.
- Large Group Plan NOT updated to meet the 2014 ACA requirements – These plans are available to businesses with 51 or more employees and are also known as grandfathered large group plans or transitional large group plans. Employers with grandfathered plans have had their plan since March 23, 2010, or prior. Employers with transitional plans have not changed their plan since 2013. In general, these plans have not had changes to benefits or the employee's cost since plan inception. These plans are not guaranteed to meet the benefit requirements for HIP Link and may offer benefits on a rider. Due to federal requirements, any large group policy that offers benefits on a rider cannot be HIP Link eligible. These plans would need to be verified by the state as meeting the benefit and affordability requirements.
- Non-Indiana Large Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Employers will select the type of plan offered in the employer application and attest to meeting the program's benefit requirements.

FAQs Specific to Businesses with Self-Funded Plans

75) **Q: What are the qualifications for a self-funded employer to enroll in HIP Link?**

A: Self-funded businesses with a Federal Employer Identification Number (FEIN) that have at least one employee who is an Indiana resident may be able to qualify for HIP Link. For employees to be able to participate in HIP Link, the employer must offer a HIP Link eligible health plan and pay at least 50 percent of the premium cost of the employer-sponsored health insurance.

76) **Q: What types of health plans for self-funded employers qualify for HIP Link?**

A: A self-funded plan is solely funded by the employer in which the plan design is unique to the employer. Instead of paying a premium to an insurer, the employer funds the health expenses of the employees. Insurers may act as administrators of the plan. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

The other type of self-funded plan in the program may be the following:

- Non-Indiana Self-Funded Group Plan – This plan is for a business located outside of Indiana in which the plan offered to employers that reside in Indiana is not certified in Indiana. This could include Small Group, Large Group and Self-funded plans. These plans are not guaranteed to meet the benefit requirements for HIP Link. These plans would need to be verified by the state as meeting the benefit and affordability requirements.

Employers will select the type of plan offered in the employer application and attest to meeting the program's benefit requirements.

Self-funded plan types may prefer to complete the employer application, since the employer solely funds the plan's benefits and services offered which may be unique to the employer.

Health Plans or Insurers FAQs

77) **Q: How does a health insurance plan become an eligible HIP Link plan?**

A: To become an eligible HIP Link plan, insurers can complete the application available at https://secure.in.gov/apps/fssa/insurers-application-form/ for review of benefit requirements. The application consists of providing general plan information, attesting to benefit standards, uploading summary of benefits and coverage (SBC), certificate of coverage and other relevant documents based on plan type. After the state determines benefit standards are met, the insurer will be notified of the approval decision and provided a HIP Link Plan ID for the approved plans.

Small group plans updated to meet the 2014 ACA requirements comply with the HIP Link benefit requirements and are not required to complete the online application. The Health Insurance Oversight System (HIOS) ID assigned to the small group plans is their HIP Link Plan ID.

78) **Q: Are there ongoing program requirements for a HIP Link plan?**

A: A HIP Link health plan is required to communicate any changes in their plan throughout the year that may impact benefits initially reviewed. On an annual basis, health plans must notify the state if the plan is renewed and resubmit amended benefit summaries, if applicable. Changes to HIP Link plans during annual renewal must be reviewed to maintain their eligible HIP Link plan status.

Provider FAQs

79) **Q: Can all providers receive reimbursement from HIP Link?**

A: Providers must meet the state requirements for Medicaid providers to get reimbursed for services received from HIP Link. The Medicaid provider application is available at http://provider.indianamedicaid.com/become-a-provider/ihcp-provider-enrollment-transactions.aspx**.**

80) **Q: How does the provider receive payment from HIP Link?**

A: The provider is to bill the primary insurance first and submit for the HIP Link employee's portion of the cost by completing an 837 form or mail to P.O. Box 1995, Indianapolis, IN 46207-1995. For additional billing questions, contact 1-800-457-4584.

81) **Q: What if the employee or member pays the copayment or other cost sharing for the medical services?**

A: HIP Link will not allow or accept receipts from employees or members for medical expenses paid for services received from IHCP enrolled providers. The provider is to resubmit the HIP Link claim to the state and reimburse the member.

82) **Q: Can pharmacy copays be paid by HIP Link?**

A: Yes, HIP Link provides supplemental coverage for the plan costs that are the member's out-of-pocket responsibility, such as deductibles, copayments and coinsurance.

83) **Q: Will the HIP Link plan benefits covered by the employer-sponsored insurance be reimbursed at the Medicaid rate?**

A: No, the HIP Link plans are employer-sponsored plans in the private or commercial insurance market. Rates will be based on network contracts with the insurer for the commercial coverage.

84) **Q: Will Medicaid benefits be covered?**

A: The covered benefits in HIP Link are the benefits provided in the employer's group health plan. The following benefits will be wrapped benefits:

1) Services provided at federally qualified health centers (FQHCs) or rural health centers (RHCs) regardless if the center is in the commercial plan network or covered by the employer plan (provided it is covered by Medicaid);

2) 72 hour emergency supply of prescription medications;

3) Family planning services not covered by the plan;

4) Non-emergency transportation for limited populations including woman who is pregnant and elected to maintain coverage in HIP Link after the annual redetermination period; and members that have very low income (less than $216 per month for an individual or $296 per month for a

household of 2) or have recently gotten a job after being very low income (low income parent and caretakers and transitional medical assistance.

5) Early and Periodic Screening, Diagnosis and Treatment services not covered by the plan for members that are 19 or 20 years of age.

These Medicaid covered benefits will be reimburse at Medicaid fee for services rates if not covered by the employer plan.

All other benefits that are covered on Medicaid but not on the commercial insurance will not be covered under HIP Link.

85) **Q: Will limited Medicaid benefits be reimbursed at the Medicaid rate?**

A: Yes, limited Medicaid benefits for HIP Link members will be reimbursed at the fee for service rate. Services received from FQHCs will be reimbursed at the prospective payment system (PPS) rate. In some cases, if the employer-sponsored insurance plan excludes the FQHC services, the PPS reimbursement rate may be lower than the employer plan rate in which HIP Link will pay the provider the employer plan rate. If the FQHC is covered by the employer plan, the employer plan rate will be paid if it is higher than the PPS rate.

86) **Q: Is HIP Link only for the employee?**

A: The eligible HIP Link employee may also include spouse or dependent coverage if offered by the employer and if each member meets the HIP Link program requirements. To be eligible for HIP Link, an individual must be 19 years of age or older with a household income under 138 percent of the federal poverty level and meet the HIP eligibility requirements. The employee must also meet these requirements and have access to and be eligible to participate in the HIP Link qualifying employer-sponsored insurance.

87) **Q: Will coverage be provided by the HIP Managed Care Entities (MCEs)?**

A: The HIP Link employee will not a select a MCE as in HIP. Since this is commercial coverage, the employee selects the HIP Link plan that is offered by the employer.

88) **Q: What funds are used to pay the provider?**

A: Each HIP Link employee including spouse or dependents will have a HIP Link POWER account. The state will use the funds in the Link account to pay for the member's portion of the claim when received from the provider.

89) **Q: Where can I find more information about HIP Link?**

A: Additional information is provided at HIP.IN.gov.

Additional questions or comments for employers may be sent to HIPLINK.ECT@fssa.in.gov or by contacting 1-800-457-4584.

Employees may send inquiries to HIP2.0@fsss.in.gov or contact 1-877-GET-HIP-9.